APPLICATION FOR TRANSITIONAL COMPENSATION

All information except Item 12 is to be entered by Service representative from Service records.

SECTION I - PAYEE INFORMATION
(If more than one eligible dependent, use the Remarks section on back to enter applicable information for each payee.)

1. PAYEE NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH *(YYYYMMDD)*	4. SEX *(X one)* ☐ MALE ☐ FEMALE

5. ADDRESS

a. STREET *(Include apartment number)*	b. CITY	c. STATE	d. ZIP CODE

6. RELATIONSHIP TO MEMBER *(X one)*

☐ SPOUSE ☐ FORMER SPOUSE ☐ CHILD ☐ ADOPTED CHILD ☐ STEPCHILD

7. CUSTODY *(If payee is spouse or former spouse, enter names of dependent children from Item 23 who are in payee's custody) (If all, enter "ALL")*

8. INCAPACITATION

YES	NO	*(X Yes or No for each item)*
		a. IS PAYEE INCAPACITATED? *(If Yes, complete Items 8.b. and c., and Item 9.)*
		b. IS PAYEE INCAPABLE OF HANDLING FINANCIAL AFFAIRS? *(If Yes, complete Item 10.)*
		c. IS PAYEE INCAPABLE OF SELF SUPPORT?

9. IS INCAPACITY: *(X one) (If applicable)* ☐ PERMANENT ☐ TEMPORARY

10. LEGAL REPRESENTATIVE *(Complete only if legal representative is not the payee.)*

a. NAME *(Last, First, Middle Initial)*	b. STREET ADDRESS *(Include apartment/suite no.)*	c. CITY	d. STATE	e. ZIP CODE

11. IF PAYEE IS A CHILD: *(X Yes or No for each item.) (NOTE: Age of majority for a child is 18 in all states except the following: Alabama, Nebraska and Wyoming: age of majority is 19; Mississippi, West Virginia and Puerto Rico: age of majority is 21.)*

YES	NO	
		a. WAS INCAPACITY INCURRED BEFORE AGE 18?
		b. IF INCAPACITY WAS INCURRED BETWEEN AGES 18 AND 23, WAS THE CHILD A FULL-TIME STUDENT?
		c. IS CHILD UNDER THE AGE OF MAJORITY? *(See NOTE. If Yes, complete Item 10.)*
		d. WAS CHILD DEPENDENT ON FORMER MEMBER FOR OVER ONE-HALF OF SUPPORT?

12. PAYEE CERTIFICATION *(Payee must sign and date to certify that the statements below are correct. Lines (2)-(4) apply only to spouse or former spouse.)*

(1) I am not cohabiting with the former member. If status changes, I will notify DFAS within 30 days.
(2) I have not remarried. If status changes, I will notify DFAS within 30 days.
(3) I have custody of the dependent children listed in Item 7.
(4) I was married to the member in Item 14 at the time of the dependent abuse offense resulting in his conviction/administrative separation.
(5) I claim payment of transitional compensation under Section 1059, Title 10, U.S.C.
(6) I understand that I may not receive payments under both Section 1059 and Section 1408(h) of Title 10, U.S.C., and that, if eligible for both, I must elect which to receive. I elect payment of transitional compensation under Section 1059.

a. SIGNATURE *(Applicant acknowledges that acceptance of payments if the offender rejoins household is punishable under the law.)*	b. DATE SIGNED *(YYYYMMDD)*

SECTION II - MEMBER IDENTIFICATION

13. BRANCH OF SERVICE *(X one)* ☐ AIR FORCE ☐ MARINE CORPS ☐ ARMY ☐ NAVY	14. MEMBER NAME *(Last, First, Middle Initial)*	15. PAY GRADE *(Prior to conviction or separation)*

16. SOCIAL SECURITY NUMBER	17. DATE OF BIRTH *(YYYYMMDD)*	18. SEX *(X one)* ☐ MALE ☐ FEMALE

19. OBLIGATED SERVICE DATES *(YYYYMMDD)*

a. ACTIVE DUTY SERVICE ENTRY DATE	b. EXPIRATION OF ACTIVE OBLIGATED SERVICE *(Enlisted only)*	c. ESTABLISHED DATE OF SEPARATION AT TIME OF CONVICTION/ADMINISTRATIVE SEPARATION *(Officer only) (If none, so state)*

20. DATE OF APPROVAL OF THE COURT-MARTIAL SENTENCE/ ADMINISTRATIVE SEPARATION *(YYYYMMDD) (If court-martial, verify date with approving official. If administrative separation, use date of initiation of separation.)*

21. PAYMENT DATES *(YYYYMMDD) (Start date is date in Item 20. Length of payment is 36 months except as follows: Subtract date in Item 19.b. or 19.c. from the date in Item 20. If less than 36 months, length of payment is that period or 12 months, whichever is greater.)*

a. START	b. STOP

22. APPROVING OFFICIAL CERTIFICATION.

I certify that the offense resulting in court-martial conviction or involved in administrative separation is a dependent-abuse offense in accordance with DoD regulations. If married, the spouse was not a participant in the abuse offense.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. TITLE	d. TELEPHONE *(Include area code)*

e. STREET ADDRESS *(Include apartment or suite number)*	f. CITY	g. STATE	h. ZIP CODE

23. DEPENDENT CHILDREN AT THE TIME OF THE ABUSE *(Continue in Remarks if necessary)*

NAME *(Last, First, Middle Initial)* **a.**	**SOCIAL SECURITY NUMBER b.**	**DATE OF BIRTH** *(YYYYMMDD)* **c.**

SECTION III - REMARKS *(Use this area to continue items as necessary. Reference each entry by item number.)*

SECTION IV - APPROPRIATION DATA

24. DFAS-DE IS AUTHORIZED TO CITE THE FOLLOWING APPROPRIATIONS FOR PAYMENT:

25. FUND CITE APPROVING OFFICIAL

a. SIGNATURE	**b. DATE SIGNED** *(YYYYMMDD)*	**c. TITLE**	**d. TELEPHONE** *(Include area code)*	
e. STREET ADDRESS *(Include apartment or suite number)*		**f. CITY**	**g. STATE**	**h. ZIP CODE**